DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

E FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 2

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TRATOR
NCING ADMINISTRATION
ALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1,2001

AL *(Check One)*:

LAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

OMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.167

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att.3.1A, Page 10,;Att.3.1B, Page8b; Att.3.1A, Item 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att.3.1A, Page 10; Att.3.1B, Page 8b; Att.3.1A Item 26

10. SUBJECT OF AMENDMENT:
Personal Care Aides - Provision of services at the worksite.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Kieffat

13. TYPED NAME:
Robert J. Saiffert

14. TITLE:
Medicaid Administrator

15. DATE SUBMITTED:
02/06/01

16. RETURN TO:
HHS, F & S - Medicaid
Attn: Dana McNeil
P.O. Box 95026
Lincoln, NE 68509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
02/09/01

18. DATE APPROVED:
APR 02 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Curtiss
Seiffert

SPA CONTROL

Date Submitted 02/06/01
Date Received 02/09/01

FORM HCFA-179 (07-92)

Instructions on Back

State: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X Provided ____ Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
- ___ State Approved (Not Physician) Service Plan Allowed
- X Services Outside the Home Also Allowed *
- X Limitations Described on Attachment

___ Not Provided.

* Exception described on attachment.

State: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X Provided ____ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
___ State Approved (Not Physician) Service Plan Allowed
X Services Outside the Home Also Allowed *
X Limitations Described on Attachment

___ Not Provided.

* Exception described on attachment.

Substitute per letter dated 2/27/01

ATTACHMENT 3.1-A
Item 26
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PERSONAL CARE AIDE SERVICES

NMAP covers personal care aide services when ordered by the client's physician based on medical necessity.

NMAP generally limits personal care aide services to 40 hours per client per seven-day period, subject to utilization review. Medicaid Division approval must be obtained for services authorized in excess of 40 hours per week.

NMAP considers a personal care aide to be a "trained" aide when the provider meets one of the following criteria and presents a copy of the certificate or license to the worker. The provider must:

1. Have successfully completed the American Red Cross Home-Bound Care Course or a basic aide training course that has been approved by the Nebraska Health and Human Services System;
2. Have passed the Nurse Aide Equivalency test; or
3. Be a licensed R.N. or L.P.N.

Exception: Personal care aide services may be provided at a client's work site when the client is engaged in competitive integrative employment, e.g., assistance with toileting or eating a meal. Competitive integrative employment is defined as working a minimum of 40 hours/month at minimum wage.

Telehealth:

Personal care aide services are not covered when provided via telehealth technologies.

Transmittal # MS-01-02

Supercedes Approved APR 02 2001 Effective JAN 01 2001

Transmittal # MS-00-06